

HOW TO FILE AN APPLICATION FOR ADJUDICATION OF CLAIM

This form should be completed to establish a case before the Workers' Compensation Appeals Board (WCAB).

Generally this form is filed when there is a dispute that cannot be resolved informally.

Complete the form and follow the instructions on the back.

Please note a hearing will not be scheduled until a Declaration of Readiness to Proceed is filed (refer to I&A Guide 07).

The following documents must be included with the completed application:

- (1) A copy of the Employee's Claim for Workers' Compensation Benefits (required only for injuries between 1-1-90 and 12-31-93). See I&A Guide 01.
- (2) Declaration required by Labor Code Section 4906(g). See attached.

A proof of service is recommended. See attached.

Send the originals to the WCAB and a copy to the insurance company.

Keep a copy for your records.

If you need help you may call an Information and Assistance Office. The local phone numbers are listed on the back of this guide.

The information contained in this guide is general in nature and is not intended as a substitute for legal advice. Changes in the law or the specific facts of your case may result in legal interpretations which are different than presented here.

WORKERS' COMPENSATION APPEALS BOARD

DISTRICT OFFICES

ANAHEIM, 92801 1661 N. Raymond Avenue, Ste. 200 Information & Assistance Unit	(714) 738-4038	SALINAS, 93906 1880 North Main Street, 1st Floor Information & Assistance Unit	(408) 443-3058
BAKERSFIELD, 93309 1800 30th Street, Rm.100 Information & Assistance Unit	(661) 395-2514	SAN BERNARDINO, 92401-1888 464 West Third Street, Ste. 239 Information & Assistance Unit	(909) 383-4522
EUREKA, 95501-0421 100 "H" Street, Rm. 201 Information & Assistance Unit	(707) 441-5723	SAN DIEGO, 92101-3690 1350 Front Street, Ste. 3012 Information & Assistance Unit	(619) 525-4589
FRESNO, 93721-2280 2550 Mariposa Street, Rm. 4078 Information & Assistance Unit	(559) 445-5355	SAN FRANCISCO (DISTRICT OFFICE), 94102 455 Golden Gate Ave., 2nd Floor Information & Assistance Unit	(415) 703-5020
GOLETA, 93117 6755 Hollister Avenue Information & Assistance Unit	(805) 968-4158	SAN JOSE, 95113 100 Paseo de San Antonio, Rm. 223 Information & Assistance Unit	(408) 277-1292
GROVER BEACH, 93433-2261 1562 Grand Avenue Information & Assistance Unit	(805) 481-3296	SANTA ANA, 92701-4080 28 Civic Center Plaza, Ste. 451 Information & Assistance Unit	(714) 558-4597
LONG BEACH, 90802-4460 300 Oceangate Street, 3 rd Floor Information & Assistance Unit	(562) 590-5240	SANTA MONICA, 90405-5200 2701 Ocean Park Blvd., Std. 222 Information & Assistance Unit	(310) 452-1188
LOS ANGELES, 90013 340 West 4 th Street, 9 th Floor Information & Assistance Unit	(213) 576-7389	SANTA ROSA, 95404 50 "D" Street, Ste. 430 Information & Assistance Unit	(707) 576-2452
OAKLAND, 94612 1515 Clay Street, 6th Floor Information & Assistance Unit	(510) 622-2861	STOCKTON, 95202-2314 31 East Channel Street, Rm. 417 Information & Assistance Unit	(209) 948-7980
POMONA, 91766 435 W. Mission Blvd., Suite 300 Information & Assistance Unit	(909) 623-8568	VAN NUYS, 91401-3373 6150 Van Nuys Blvd., Rm 105 Information & Assistance Unit	(818) 901-5374
REDDING, 96001-2796 2115 Akard, Rm. 21 Information & Assistance Unit	(530) 225-2047	VENTURA, 93003-6085 5810 Ralston Street, Rm. 115 Information & Assistance Unit	(805) 654-4701
RIVERSIDE, 92501 3737 Main Street, Ste. 300 Information & Assistance Unit	(909) 782-4347	WALNUT CREEK, 94598 175 Lennon Lane, Rm. 200 Information & Assistance Unit	(925) 977-8343
SACRAMENTO, 95825 2424 Arden Way, Ste. 230 Information & Assistance Unit	(916) 263-2741		

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS

WORKERS' COMPENSATION APPEALS BOARD

SEE REVERSE SIDE
FOR INSTRUCTIONS

APPLICATION FOR ADJUDICATION OF CLAIM

(PRINT OR TYPE NAMES AND ADDRESSES)

CASE No. _____

M _____

(INJURED EMPLOYEE'S ADDRESS AND ZIP CODE)

Social Security No.: _____

(APPLICANT, IF OTHER THAN INJURED EMPLOYEE
VS.

(APPLICANT'S ADDRESS AND ZIP CODE)

(EMPLOYER--STATE IF SELF-INSURED)

(EMPLOYER'S ADDRESS AND ZIP CODE)

(EMPLOYER'S INSURANCE CARRIER OR, IF SELF-INSURED, ADJUSTING AGENCY)

(INSURANCE CARRIER OR ADJUSTING AGENCY'S ADDRESS)

IT IS CLAIMED THAT:

1. The injured employee, born _____ (DATE OF BIRTH), while employed as a _____ (OCCUPATION AT TIME OF INJURY)
on _____ (DATE OF INJURY) at _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP CODE)
By the employer sustained injury arising out of and in the course of employment to

(STATE WHAT PARTS OF THE BODY WERE INJURED)

2. The injury occurred as follows: _____ (EXPLAIN WHAT EMPLOYEE WAS DOING AT THE TIME OF INJURY AND HOW INJURY WAS RECEIVED)
3. Actual earnings at the time of injury were: _____ (GIVE WEEKLY OR MONTHLY SALARY OR HOURLY RATE AND NUMBER OF HOURS WORKED PER WEEK)
- _____ (SEPARATELY STATE VALUE PER WEEK OR MONTH OF TIPS, MEALS, LODGING OR OTHER ADVANTAGES REGULARLY RECEIVED)

4. The injury caused disability as follows: _____ (SPECIFY LAST DAY OFF WORK DUE TO THIS INJURY AND BEGINNING AND ENDING DATES OF ALL PERIODS OFF DUE TO THIS INJURY)

5. Compensation was paid (YES) (NO) \$ _____ (TOTAL PAID) \$ _____ (WEEKLY RATE) _____ (DATE OF LAST PAYMENT)

6. Unemployment insurance or unemployment compensation disability benefits have been received since the date of injury
(YES) (NO)

7. Medical treatment was received (YES) (NO) _____ (DATE OF LAST TREATMENT) All treatment was furnished by
the Employer or Insurance Company (YES) (NO) Other treatment was provided or paid by _____

_____ (NAME OF PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE) Did Medi-Cal pay for any health care
related to this claim (YES) (NO) doctors not provided or paid for by employer or insurance company who treated or examined
for this injury are _____ (STATE NAMES AND ADDRESSES OF SUCH DOCTORS AND NAMES OF HOSPITALS TO WHICH SUCH DOCTORS ADMITTED INJURED)

8. Other cases have been filed for industrial injuries by this employee as follows: _____
_____ (SPECIFY CASE NUMBER AND CITY WHERE FILED)

9. This application is filed because of a disagreement regarding liability for: Temporary disability indemnity _____
Permanent disability indemnity _____ Reimbursement for medical expense _____ Medical treatment _____
Compensation at proper rate _____ Rehabilitation _____ Other (Specify) _____ AND APPLICANT REQUESTS A HEARING AND

AWARD OF THE SAME, AND FOR ALL OTHER APPROPRIATE BENEFITS PROVIDED BY LAW.

Dated at _____ (CITY), California _____ (DATE)

(APPLICANT'S ATTORNEY)

(APPLICANT'S SIGNATURE)

(ADDRESS AND TELEPHONE NUMBER OF ATTORNEY)

INSTRUCTIONS

FILING AND SERVICE OF A DECLARATION OF READINESS (DIA/WCAB Form 9) IS PREREQUISITE TO THE SETTING OF A CASE FOR HEARING.

Effect of Filing Application

Filing of this application begins formal proceedings against the defendants named in your application.

Assistance in Filling Out Application

You may request the assistance of an information and assistance officer of the Division of Industrial Accidents.

Right to Attorney

You may be represented by an attorney or agent, or you may represent yourself. The attorney fee will be set by the Board at the time the case is decided and is ordinarily payable out of your award.

Filling Out Application

All blanks in the application shall be completed. Where the information is unknown, place "unknown" in the blank. If *medical treatment is paid for by Medi-Cal, Medicare, group health insurance or private carrier, please specify.*

Service of Documents

Your attorney or agent will serve all documents in accord with Labor Code Section 5501 and Section 10500 of the Workers' Compensation Appeals Board's Rules of Practice and Procedure.

If you have no attorney or agent, copies of this application will be served by the Workers' Compensation Appeals Board on all parties. If you file any other document, you must mail or deliver a copy of the document to all parties in the case.

IMPORTANT!

If any applicant is under 18 years of age, it will be necessary to file Petition for Appointment of Guardian ad Litem. Forms for this purpose may be obtained at the office of the Workers' Compensation Appeals Board.